September 23, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-03-1782-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___is a 61-year-old woman who injured her lower back on ___. At that time she had a L3/4 disc herniation and underwent a laminectomy at L3/4 by ___. The surgery was done in June of 2001. Records indicate she was pain-free and was able to return to work at ___Six months after returning to work she began having recurrent pain in the right leg and lower back. She was then seen by ___and ___.

An MRI of the lumbar spine was performed at ___ which demonstrated lumbar degenerative disc disease and post-operative changes. This patient also had a discogram from L3 through S1 ordered by ___ on April 25, 2003. It demonstrated recurrent back pain at L4/5 and possible L5/S1. The L3/4 was not painful.

___was seen by ___ on June 13, 2003. It was his opinion that she had mechanical back pain form L3/4 but no significant radicular findings. He had recommended flexion and extension views of the lumbar spine. On July 14, 2003 ___ reviewed the flexion and extension views that demonstrated instability at L3/4, retrolesthesis at L3 on L4 with collapsing posterior intraspace at the level of L3/4. It is noted that the patient had persistent pain and ___ recommended posterior lumbar interbody fusion using BAK threaded cage devices and a disc incision at L3/4.

Records indicate the patien ttakes Vioxx, Norvasc, prevachol and syntroid. She is approximately 5'8 and weights about 145 pounds. She is neurologically intact with pain in her lower back. It is also noted that she has been treated with non-surgical methods to in clued physical therapy, anti-inflammatory medicines and steroid injections with little to no long-term relief.

REQUESTED SERVICE

Lumbar laminectomy with fusion with cage devices at L3/4 is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___is a 61-year-old woman who sustained an L3/4 herniated disc in a work-related injury on ___. She was treated with a discectomy in 2001. She subsequently had recurrent lower back pin consistent with spinal instability at L3/4. This has been confirmed with flexion extension views. She has failed non-operative methods.

Based on the above information, the reviewer finds that the proposed L3/4 lumbar laminectomy with fusion with BAK cage devices would be reasonable and necessary. This opinion is based on peer review literature on this matter along with treatment guidelines presented by the AAOS for lumbar spinal instability.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 23rd day of September 2003.